SURGERY

UNDER THE CHARGE OF

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Operation for the Removal of Ascites.—KUMARIS (*Zentralbl. f. Chir.*, 1914, xli, 1609) in a previous number (No. 43, 1914) of the *Zentralblatt* (for abstract see AMER. JOUR. MED. SCI., 1914, cxlvii, 910) recommended the removal of an extensive portion of the parietal peritoneum in order to favor the widest possible adhesions between the intestines and abdominal wall. One patient upon whom this operation was done died of facial erysipelas twenty-two days after the operation and at autopsy a hardly demonstrable quantity of fluid was found in the abdomen. Hans Lorenz did it in combination with Lanz's scrotum operation. A month later the patient was in good health and the ascites was no longer demonstrable. Kumaris operated on a fifty-five-year-old man with ascites. The parietal peritoneum was removed as high as possible, and from the ascending mesocolon on the right side almost to the colon on the left side. A tongue-shaped piece of peritoneum was brought out of the lower angle of the incision in the peritoneum and a piece of omentum was laid on the summit of the bladder and in the depth of the exposed space of Retzius. A considerable portion of the prevertebral peritoneum was also separated. After forty-eight hours, the edema about the ankles had disappeared, the abdomen was completely painless and there was no edema of the abdominal walls. Fluid escaped between the sutures in the upper part of the wound for a few days. After fourteen days puncture of the abdomen for the relief of fluid was no longer necessary and after six months the patient enjoyed complete health, no fluid was demonstrable and there was no edema. There still remains a slight jaundice from the chief liver complaint.

The Treatment of Presternal Dislocation of the Clavicle.—DANIELSEN (*Zentralbl. f. Chir.*, 1914, xli, 1561) says that this disolocation is rare, is easily recognized and reduced but that the retention of the bone in its normal position has been impossible. Notwithstanding the persistence of the dislocation, the prognosis for good function is generally good. Sometimes the protruding end of the bone causes so severe pain that excision is called for. In other cases the end of the clavicle fails to develop adhesions and the resulting movements give considerable disturbance. In one case reported by Riedinger, because of this mobility, the patient could not abduct the arm more than 45 degrees. Danielsen says that in assuming that the shoulders should be forced backward to maintain the reduction, we have been wrong. In a recent case he forced the shoulders forward and maintained them in this position by raising the arm upward so that it lay against the cheek and the forearm was over the head. The arm was bandaged in this position and the dislocation remained reduced. Healing occurred without disturbance and the movements became free and painless.

Treatment of Forward Dislocations of the Clavicle.—BRAATZ (*Zentralbl. f. Chir.*, 1914, xli, 1673) agrees with Danielsen that the generally advised methods of bandaging the arm are wrong, especially the forcing of the shoulders backward, but he obtained complete success by a different method than that employed by Danielsen. He saw the dislocation in a three-year-old boy on the day of the accident. It was easily reduced under narcosis but as soon as the shoulder was pressed backward the dislocation recurred. He placed the arm in the right angled position across the front of the chest without restraint and pressed the shoulder forward. Then over the joint he placed a pad of cotton which was held in place by a strip of adhesive plaster passing obliquely from the back over the shoulder to the left breast. Other adhesive strips were used to reinforce the first and with a bandage the shoulder was fixed in the forward position. A Roentgen ray taken on the following day showed the bones in their normal position. The adhesive was reinforced after fourteen days and a new bandage applied over the whole arm and hand. A Roentgen ray at this time showed the dislocation still completely reduced. The dressing was finally removed at the end of eight weeks and at the end of five months the bones were still in their normal positions. Four weeks retention of the bandage will be sufficient in an adult.

Clinical and Experimental Studies of Hormonal and Neohormonal.—DENCKS (*Deut. Zeitschr. f. Chir.*, 1914, cxxxii, 37) studied the effects of these substances on peristalsis in forty animal experiments and about 140 patients observed at the bedside. The claim of Zuelzer, Dohrn, and Marxer that hormonal is a specific in exciting peristalsis has not been sustained. It is a powerful stimulant of peristalsis in animals and men, as well by intravenous as by intramuscular injections. In favorable cases of chronic constipation, the effect of the preparation has been observed to continue for several years. It frequently fails, however, in animals and men. The dangers associated, which are largely due to lowering of the blood-pressure, have been obviated by an improvement of the preparation, neohormonal. This preparation is indicated in all cases of postoperative disturbance of peristalsis and in all forms of chronic constipation. In mild cases of intestinal paresis and those of moderate severity, the neohormonal may be injected into a muscle. At first 20 c.c. should be injected and if a satisfactory effect is not obtained in four to six hours, a second dose should be given and by preference intravenously. At first 20 c.c. should be injected slowly with the usual syringe, and repeated in four to six hours if a satisfactory result is not obtained. In especially severe cases where a very quick effect is necessary, 30 to 40 c.c. should be injected intravenously and